MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
APPENDICES

Page #

1. National HCFA 1500 Claim Form Instructions for Non-51.42 Board Operated Psychotherapy/Alcohol and Other Drug Abuse Services 1H5-003

2. Sample HCFA 1500 Claim Form Samples

   2a. Non-51.42 Board Psychotherapy Services 1H5-009
   2b. Non-51.42 Board AODA Services 1H5-011

3. WMAP Allowable Procedure Codes for Non-51.42 Board Providers 1H5-013

4. Instructions for the Completion of the Prior Authorization Request Form (PA/RF) for Psychotherapy/Alcohol and Other Drug Abuse Services 1H5-015

5. Sample Prior Authorization Request Forms (PA/RF)

   5a. Psychotherapy 1H5-017
   5b. AODA 1H5-019
   5c. Evaluation and Testing 1H5-021

6. Instructions for the Completion of the Prior Authorization Psychotherapy Attachment (PA/PSYA) 1H5-023

7. Sample Prior Authorization Psychotherapy Attachment (PA/PSYA) 1H5-027

8. Summary of Outpatient Psychotherapy Prior Authorization Guidelines (for use with the Prior Authorization Psychotherapy Attachment: PA/PSYA) 1H5-029

9. Instructions for the Completion of the Prior Authorization AODA Attachment (PA/AA) 1H5-031

10. Sample Prior Authorization AODA Attachment (PA/AA) 1H5-033

11. Summary of Outpatient AODA and AODA Intensive Outpatient Treatment Prior Authorization Guidelines (for use With the Prior Authorization AODA Attachment: PA/AA) 1H5-037

12. Instructions for the Completion of the Prior Authorization Evaluation and Testing Attachment (PA/ETA) 1H5-039

13. Sample Prior Authorization Evaluation and Testing Attachment (PA/ETA) 1H5-041

14. Summary of Prior Authorization Guidelines for the Prior Authorization Evaluation and Testing Attachment (PA/ETA) 1H5-043

15. Copayment Schedule for Psychotherapy and AODA Services 1H5-045

16. WMAP Allowable Place of Service (POS) and Type of Service (TOS) Codes for Non-51.42 Board-Operated Clinics 1H5-047

MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE SERVICES
APPENDICES
(continued)

Page #

17. Rounding Guidelines 1H5-049

18. WMAP Allowable Procedure Codes for Neuropsychological Testing 1H5-051

19. Billing Hints for Mental Health Services Billed on the HCFA 1500 Claim Form 1H5-053

20. Billing Hints for Mental Health Services Sample Claim Form 1H5-055

21. Paperless Claims Request Form 1H5-057

22. Wisconsin Peer Review Organization (WIPRO) Review Process 1H5-059

APPENDIX 1
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR NON-51.42 BOARD OPERATED PSYCHOTHERAPY/ ALCOHOL AND OTHER DRUG ABUSE SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Health insurance must be billed prior to billing the WMAP, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

  Code Description

  OI-P PAID in part by health insurance. The amount paid by health insurance to the provider or the insured is indicated on the claim.

  OI-D DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.

  OI-Y YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

  - the recipient denies coverage or will not cooperate;
  - the provider knows the service in question is noncovered by the carrier;
  - health insurance failed to respond to initial and follow-up claim; or
  - benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

  Code Description

  OI-P PAID by HMO or HMP. The amount paid is indicated on the claim.

  OI-H HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code Description

M-1 Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.

M-5 Provider not Medicare certified for the benefits provided.

M-6 Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name. For psychotherapy/AODA services, the prescribing physician's name is required for all services except evaluation (90801) and limitation exceeded psychotherapy (W8987). If a psychiatrist is the referring or prescribing provider and the performing provider, the psychiatrist's name must be entered in this element.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required. Refer to Appendix 3 of this handbook for allowable diagnosis codes for psychotherapy and AODA services.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month

(i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 16 of this handbook for a list of allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code. Refer to Appendix 16 of this handbook for a list of allowable type of service codes.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for the list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed on each line item. A decimal must be indicated when a fraction of a whole unit is billed.

For all psychotherapy/AODA services, except chemotherapy management (90862), one unit equals one hour. However, services should be billed in tenths of an hour, based on six-minute increments.

For chemotherapy management, one unit equals 15 minutes. Providers may round to the nearest whole unit (up to two units per date of service) or bill fractions of a unit.

Refer to Appendix 17 of this handbook for rounding guidelines to be used when submitting claims.

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure that was performed as the result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33. When billing chemotherapy management (medication check) performed by an RN (90862, TOS 9), enter the eight-digit Medical Assistance provider number of the RN if available, or the Medical Assistance provider number of the supervising physician if the RN is not separately certified with the WMAP. Any other information entered in this element may cause claim denial.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 2A

NON-51.42 BOARD PSYCHOTHERAPY SERVICES

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1 MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
(Medicare #) [P] (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☐ F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: — STATE:

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M - 1

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M.Referring/Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 296.35
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER: 1234567

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 06 92	20	3	9	90844		1	XXX XX	2.0				11223344
2 02 13 92		3	9	90847		1	XX XX	1.0				11223344
3 02 15 92		3	1	90862		1	XX XX	1.0				44332211
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XXX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M.Provider MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M.Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 2B

NON-51.42 BOARD AODA SERVICES

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: — STATE:

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M.Referring/Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 303.91
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24 A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01	14	92	21	28		3	1	W8968		1	XXX XX	3.0				11223344
2 01	14	92				3	1	W8969		1	XX XX	1.0				11223344
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M.Billing
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX 3
WMAP ALLOWABLE PROCEDURE CODES FOR NON-51.42 BOARD PROVIDERS

The following table lists the HCPCS procedure codes and description to be used for billing mental health and AODA services, who may bill the codes, what limitations apply, and their allowable diagnoses.

Codes Which May Be Billed by Non-51.42 Board Providers

Proc. Code	Description	Who May Provide Service	Limitations**	Allowable Diagnoses
90801	Psychiatric Evaluation	M.D.,* Ph.D., M.S.	6 hrs./2 years	All
90835	Narcosynthesis	M.D.,* Ph.D.	PA	290-316
90844	Individual Psychotherapy	M.D.,* Ph.D., M.S.	PA	290-316
90845	Medical Psychoanalysis	M.D.,* Ph.D., M.S.	PA	290-316
90846	Family Medical Psychotherapy (without recipient present)	M.S.,* Ph.D., M.S.	PA	290-316
90847	Family Psychotherapy	M.D.,* Ph.D., M.S.	PA	290-316
90849	Multiple-Family Group	M.D.,* Ph.D., M.S.	PA, not allowable for POS 1	290-316
90853	Group Psychotherapy	M.D.,* Ph.D., M.S.	PA, not allowable for POS 1	290-316
90862	Chemotherapy Management (Medication Check) (15 minutes)	M.D., R.N.	30 min./day 4/month, not allowable for POS 1	290-316
90870/ 90871	Electroconvulsive Therapy	M.D.	Not allowable for POS 7 or 8	290-316
90880	Hypnotherapy	M.D.,* Ph.D., M.S.	PA	290-316, except 305.10
90887	Collateral Interview	M.D.,* Ph.D., M.S.	PA	290-316
90900	Biofeedback	M.D., Ph.D., M.S.		307.80, 307.81, 346.0-346.9, and 784.0
90904	Biofeedback	M.D., Ph.D., M.S.		401.0-401.9

* Physician must be a psychiatrist in order to bill this code.

** Codes with the "PA" limitation accumulate toward the 15 hour/$500 yearly threshold per recipient beyond which prior authorization is required.

NOTE: Services provided by master's level providers or AODA counselors are not billable in POS 1.

ADDITIONAL NOTE: Prior authorization is not required for services provided at the inpatient hospital setting (POS 1).

Proc. Code	Description	Who May Provide Service	Limitations**	Allowable Diagnoses
90908	Biofeedback	M.D., Ph.D., M.S.		300.00, 300.01, 300.02, and 300.21
W8968	Individual AODA Therapy	M.D., Ph.D., M.S., A.C.	PA	290-316
W8969	Group AODA Therapy	M.D., Ph.D., M.S., A.C.	PA, not allowable for POS 1	290-316
W8970	Family AODA Therapy	M.D., Ph.D., M.S., A.C.	PA	290-316
W8987	Limitation - Exceeded Psychotherapy/AODA Evaluation	M.D.,* Ph.D., M.S.	PA	All

* Physician must be a psychiatrist in order to bill this code.

** Codes with the "PA" limitation accumulate toward the 15 hour/$500 yearly threshold per recipient beyond which prior authorization is required.

NOTE: Services provided by master's level providers or AODA counselors are not billable in POS 1.

ADDITIONAL NOTE: Prior authorization is not required for services provided at the inpatient hospital setting (POS 1).

APPENDIX 4
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR PSYCHOTHERAPY/ALCOHOL AND OTHER DRUG ABUSE SERVICES

ELEMENT 1 - PROCESSING TYPE

Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Prior Authorization requests will be returned without adjudication if no processing type is indicated.

126 - Psychotherapy
128 - AODA Services

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Enter the ten-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME

Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS

Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX

Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE

Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the clinic name and number as the billing provider.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the clinic telephone number.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

Enter the eight-digit Medical Assistance provider number of the billing provider. Non-billing performing providers (master's degree psychotherapists or AODA counselors) must indicate the eight-digit Medical Assistance provider number of the clinic.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS

Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis code is not required on prior authorization requests for psychiatric evaluation or diagnostic tests.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition. A diagnosis code is not required on prior authorization requests for psychiatric evaluation or diagnostic tests.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate single-digit place of service code designating where the requested service would be performed. Refer to Appendix 16 of this handbook for a list of allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate single-digit type of service code for each service requested. Refer to Appendix 16 of this handbook for a list of allowable type of service codes.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the number of hours requested for each service requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1", multiply the quantity by the charge for each service requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medical Assistance Program payment methodology and policy. If the recipient is enrolled in a WMAP-contracted managed care program at the time a prior authorized service is provided, WMAP reimbursement is allowed only if the service is not covered by the managed care program.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER – THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 5A

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

PSYCHOTHERAPY

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
126

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YY

6 SEX M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
43218700

10 DX: PRIMARY
296.35 Major Depressive Disorder

11 DX: SECONDARY
309.00 Adjustment Reaction

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
90847		3	9	Family Psychotherapy	6	XXX.XX
90844		3	9	Individual Psychotherapy	13	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I. M. Provider, M.S. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

PA12118KJF/HB3

APPENDIX 5B

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

AODA

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 128

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 56781200

10 DX: PRIMARY: 303.91- Alcohol Dependence

11 DX: SECONDARY: 296.2 - Major Depressive Disorder

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8968		3	1	Individual AODA Therapy	2	XX.XX
W8969		3	1	Group AODA Therapy	60	XXX.XX
W8970		3	1	Family AODA	2	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 I. M. Provider, A.C. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

PA12118KJF/HB3

APPENDIX 5C

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

EVALUATION AND TESTING

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0123456

1 PROCESSING TYPE: 126

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Non Board-Operated Outpatient Psychotherapy Clinic
1 West Williams
Anytown, WI XXXXX
9 BILLING PROVIDER NO.: 12345678
10 DX: PRIMARY:
11 DX: SECONDARY:
12 START DATE OF SOI: N/A
13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
90801		3	9	Psych diagnostic interview/exam including history	2 hrs.	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 I.M. Provider, Ph.D. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

482-120

PA12118KJF/HB3

APPENDIX 6
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT (PA/PSYA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Psychotherapy Attachment (PA/PSYA) may be addressed to EDS' Telephone/Written Correspondence Unit.

GENERAL INSTRUCTIONS:

The information contained on this prior authorization psychotherapy attachment is used to make a decision about the amount and type of psychotherapy which is approved for continued Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe is of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form.

When submitting the first prior authorization request for a particular individual, please fill out page one and two. For continuing authorization on the same individual, it is not necessary to rewrite page one, unless new information has caused you to change any of the information on this page (e.g., a different diagnosis, belief that intellectual functioning is in fact significantly below average). When there has been no change in the page one information, please submit a photocopy of this page along with your updated page two. Medical consultants reviewing the prior authorization request have before them a file containing the previous requests; therefore, updates and progress need to reflect changes only from the information contained on the previous request.

Prior authorization for psychotherapy is not granted when another provider already has a prior authorization in place for psychotherapy services to the same recipient. In these cases, the recipient must request that the previous provider notify EDS that they have discontinued treatment with the recipient. The new provider must complete both page one and two for the initial prior authorization request.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME

Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME

Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL

Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE

Enter the age of the recipient in numerical form (e.g., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment (e.g., I.M. Provider, M.D. or I.M. Provider Ph.D.).

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - SUPERVISING PROVIDER'S NAME
Enter the name of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist.

ELEMENT 10 - SUPERVISING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician or psychologist who is supervising the treatment if the performing provider is a master's level therapist. (Not required for 51.42 Board-operated clinics.)

ELEMENT 11 - PRESCRIBING PROVIDER'S NAME
Enter the name of the physician who wrote the prescription for psychotherapy.

ELEMENT 12 - PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
Enter the eight-digit Medical Assistance provider number of the physician who wrote the prescription for psychotherapy. If the physician is not WMAP-certified, enter the physician's name.

DOCUMENTATION:

A. DIAGNOSIS: Enter the diagnosis codes and descriptions from the most recent version of DSM. Axis IV and V are optional, but are strongly encouraged when a provider is requesting a continuing authorization for a recipient.

B. DATE TREATMENT BEGAN: Date of first treatment by this provider.

C. DIAGNOSED BY: Indicate the procedure(s) used to make the diagnosis.

D. CONSULTATION: Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

E. RESULTS OF CONSULTATION: Summarize the results of this consultation or attach a copy of the consultant's report.

F. PRESENTING SYMPTOMS: Enter the presenting symptoms and indicate their degree of severity. This information may be provided as part of an intake summary which you may attach to this request form.

G&H. INTELLECTUAL FUNCTIONING: Indicate whether intellectual functioning is significantly below average (e.g., I.Q. below 80). If "yes", indicate the IQ or intellectual functioning level.

I. HISTORICAL DATA: This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

J. PRESENT GAF: Enter the global assessment of functioning scale score from the most recent version of DSM. For continuing authorization requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

K. PRESENT MENTAL STATUS/SYMPTOMATOLOGY: Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is not acceptable to send progress notes which do not summarize the progress to date.

L. UPDATED HISTORICAL DATA: For continuing requests, indicate any new information about the recipient's history which may be relevant to a determination of the need for continued treatment.

M. TREATMENT MODALITIES: Indicate the treatment modalities to be used.

N. NUMBER OF MINUTES PER SESSION: Indicate the length of session for each modality.

O&P. FREQUENCY OF REQUESTED SESSIONS AND TOTAL NUMBER OF SESSIONS YOU ARE REQUESTING: If you are requesting sessions more than once a week, please indicate the need for this. If you anticipate a series of treatment which is not regular (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment you are requesting, the time period over which you are requesting the treatment, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

EXAMPLE: 15 hours of treatment is requested over a 12-week period. The recipient attends a one and one-half hour group every other week (6 groups for a total of 9 hours). There are individual sessions of one hour weekly for four weeks, and every other week for the next four weeks (6 individual sessions for a total of 6 hours).

Q. PSYCHOACTIVE MEDICATION: Indicate all the medications the recipient is taking which may be affecting the symptoms you are treating. Indicate whether a medication review has been done in the past three months.

R. RATIONALE FOR FURTHER TREATMENT: Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is of help.

S. GOALS/OBJECTIVES OF TREATMENT: A treatment plan may be attached in response to this item.

T. STEPS TO TERMINATION: Indicate how you are preparing the recipient for termination. When available, indicate a planned date of termination.

U. FAMILY MEMBERS: If an individual provider is seeing more than one family member in individual psychotherapy, this requires adequate justification.

RECIPIENT AUTHORIZATION: Signature indicates the signer has read the form. Signature is optional.

* *

In addition to the above information, we need the following to process your prior authorization request:

1. The performing provider(s) signature on the PA/PSYA. Read the Prior Authorization Statement before dating and signing the attachment.

2. The supervising provider's signature is required only if the performing provider is not a physician or psychologist.

3. Attach a copy of the signed and dated prescription for psychotherapy. The initial prescription must be dated within three months of receipt by EDS. Subsequent prescriptions must be dated within 12 months of receipt by EDS.

NOTE: If a physician is the performing provider, a prescription need not be attached.

APPENDIX 7
PRIOR AUTHORIZATION
PSYCHOTHERAPY ATTACHMENT (PA/PSYA)

MAIL TO:
E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PSYA

PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form)
3. Attach physician prescription.
4. Attach additional information if necessary.
5. Mail to EDS

RECIPIENT INFORMATION

(1) Last Name	(2) First Name	(3) MI	(4) Medical Assistance Identification Number	(5) Age
Recipient	Im	A	1234567890	26

PROVIDER INFORMATION

(6) Performing Provider Name	(7) Performing Provider #	(8) Performing Provider's Telephone Number	MSW MS MD PHD DO PSYCH Other: ____ Discipline (circle one)
I.M.Performing	87654321	XXX-XXX-XXXX	

(9) Supervising Provider's Name	(10) Supervising Provider's Number	(11) Prescribing Provider's Name	(12) Prescribing Provider's Number
I.M.Supervising	98765432	I.M.Prescribing	12345678

A. Diagnosis: Axis I: a) major depression, recurrent, in partial remission b) adjsutment disorder with depressed mood 309.00
Axis IV: 1 2 3 4 5 6 7 8 9 0 (optional)
Axis V: (past year) 50
(optional) Highest GAF past year: 75
Axis II: rule out Historonic Personality disorder
Axis III: Seizure disorder

B. Date Treatment Began: 09/18/93 with this provider

C. Diagnosed By: X Clinical Exam __ Psychological Testing X Other (specify): MAST Hookings Symptom Checklist 90

D. Consultation: X Yes __ No Did consultant see recipient? X Yes __ No

E. Result(s) of Consultation: Medication & assessed for ability to progress in psychotherapy which was seen as positive.

F. Presenting Symptoms: Insomnia, energy; suicidal ideation, history of 1 attempt 2 yrs ago, much guilt and self reproach.
Severity: __ Mild X Moderate __ Severe

G. Is the recipient's intellectual functioning significantly below average? __ Yes X No

H. If yes to "G", what is the recipient's IQ score or intellectual functioning level? N/A

I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary): Im is from a step-family home with the step-father being "alcoholic." She was 14 yrs old when her step-brother committed suicide. Reported history of physical and sexual abuse in family of origin. Long history of depressed mood. Diagnosed as having major depression 1 yr ago when hospitalized at Anytown Hospital in Anytown, WI (12/03/92-12/31/92). No further treatment history. Seeking out help at this time due to husband being accused of abusing her 3 children. At time hospitalization, reported being very suicidal & having some auditory hallucinations. Denies AODA usage. Currently well-groomed, pleasant, no signs of psychomotor retardation. Thought and speech intact. Very tearful. Admits to suicidal thoughts; no plans. Oriented in all spheres. (See attached intake summary sheet for additional history.)

J. Present GAF (DSM): 50 Is the recipient progressing in treatment? X Yes __ No
If "no", explain:

K. Present mental status/symptomatology (include progress since treatment was initiated, or since last authorization):
Since treatment started 4 wks ago, recipient is able to sleep most of the night. Continues to be tearful & hurt about abuse situation. Having more energy to care for self. Some lack of appetite continues. Periods of anxiety are often noted.

L. Updated/historical data (family dynamics, living situation, etc.):
Recipient is considering divorce. Still separated at this time. Recipient's 3 children live with her and this has increased stress. We will begin to see her with children on an as needed basis.

M. Treatment Modalities: X Psychodynamic __ Behavior Modification __ Biofeedback
__ Play Therapy __ Other (specify): _____

N. Number of minutes per session: Individual: 60 Group: ___ Family: 60

O. Frequency of requested sessions: __ monthly X once/week X twice/month as needed __ other (specify): _____

P. Total number of sessions requested: 13 6 Family

Q. Psychoactive Medication: X Yes __ No Has there been a medication check in the past three months?
X Yes __ No

Names and dosage(s): Desipramine 150 mgs h.s. and 200mgs Dilantin for seizure disorder (total daily dose)

R. Rationale for further treatment:
1. Continues to have many life stressors (i.e. separation, child abuse, etc.)
2. Ongoing mild suicidal risk.
3. Beginning to explore own decisions around divorce with these stressors.
4. Therapy is essential to prevent hospitalization again.

S. Goals/objectives of treatment:
1. Continue to support & monitor mood; promote a positive self-image.
2. Continue to help in dealing with stress thru teaching cognitive as well as relaxation techniques for stress management.
3. Increase self-awareness of own past abuse and its relationship to current reality. 4. Begin to help with parenting skills.

T. What steps have been taken to prepare recipient for termination of treatment:
Have referred recipient to on-going self-help group to deal with past issues a round family alcoholism. It is too early to start termination process at this time; however, we have discussed the time limited nature of the psychotherapy and have set a goal of terminating in 6 months.

U. Do you see other family members in a separate process? If yes, give rationale for seeing multiple family members:
No, not at this time. A family session for diagnostic purposes is planned in the near future.

J M Performing _____ J M Supervising MM/DD/YY
Signature of Performing Provider | Recipient Signature (optional) | Signature of Supervising Provider | Date

*The provision of services which are greater than or significantly different from those authorized may result in non-payment of the claim(s).

APPENDIX 8
SUMMARY OF OUTPATIENT PSYCHOTHERAPY PRIOR AUTHORIZATION GUIDELINES (FOR USE WITH THE PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT - PA/PSYA)

Authorization for outpatient psychotherapy is granted for individuals with an appropriate DSM diagnosis, where the documentation provided supports the treatment requested. Normative authorization is for up to one 60-minute individual session per week and/or one 60-120 minute group session per week for significantly functionally disabling symptoms. Authorization usually spans a period of 13 weeks, but where therapy is non-intensive (one to two sessions per month) authorization may be for a longer period. Authorization may also be granted for a specified number of hours over the time span requested which may be used at the provider's discretion (e.g., 20 hours over a 13 week period).

Where the recipient is clearly a suicidal or homicidal risk, up to one session per day may be authorized for a short period of time. Emergency psychotherapy may be performed without prior authorization for up to eight hours in a two week period when the provider has reason to believe that harm to the recipient or others may be imminent. Authorization is conditional upon the provider expeditiously seeking authorization (within two weeks of the completion of the emergency service) and justifying the need for the emergency psychotherapy.

The following DSM diagnostic categories are generally not expected to yield to psychotherapeutic treatment alone and require extensive justification.

- mental retardation (317-319) cannot be approved if this is the primary or only diagnosis
- organic mental disorders/dementia (290.0-290.4, 310-310.9)
- alcohol related disorders (291-291.9, 303-303.9, 305.0) and drug related disorders (292.0-292.9, 304.0-304.9, 305.2-305.9): requests in these categories must demonstrate that psychotherapeutic intervention alone has a reasonable probability of remediating the disease which is diagnosed as indicated by history, previous response to treatment, etc.
- schizophrenia/delusional (paranoid) disorders and psychotic disorders not elsewhere classified (295.1-295.9, 297.3, 297.10, 298.8, 298.9). Requests in this category must demonstrate an understanding of the importance of supportive psychotherapy, community support services, family intervention and medication management.
- other disorders which experience has demonstrated are refractory to psychotherapy (e.g., some personality disorders [301]), are transitory or self-limiting (e.g., adjustment disorders [309]), or in which psychotherapy is considered to be controversial.

Other considerations:

- emphasis on family treatment is favored where conditions affect more than one family member and family issues are involved.
- requests for extension of authorization must include information updated within the past authorization period in all specific clinical areas of the prior authorization request form. Requests returned for more information do not constitute a denial of services. Providers are responsible for sending adequate, updated information to allow processing of the prior authorization request.
- therapy by two or more providers simultaneously is ordinarily not allowed.

APPENDIX 9

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION AODA ATTACHMENT (PA/AA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization AODA Attachment (PA/AA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.)

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER'S NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment.

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the eight-digit Medical Assistance provider number of the provider referring/prescribing treatment. If the provider is not WMAP-certified, enter the provider's name.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

* *

The remaining portions of this attachment are to be used to document the justification for the service requested.

- PART A - Designate the type of treatment requested (e.g., primary intensive outpatient treatment; aftercare/follow-up service; or affected family member/co-dependency treatment). Identify the types of sessions, duration, and schedule. The total hours must match the quantities indicated on the PA/RF.

  If a certified psychotherapist is requesting specific psychotherapy services for the AODA-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization Psychotherapy Attachment (PA/PSYA).

- PART B - Complete elements 1-10.

Providers may attach copies of assessments, treatment summaries, treatment plans or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

1. Attach a copy of the signed and dated prescription for AODA services. The initial prescription must be dated and signed within three months of receipt by EDS. Subsequent prescriptions must be dated within twelve months of receipt by EDS.

   NOTE: If a physician will be the performing provider, a prescription need not be attached.

2. Read the Prior Authorization Statement before dating and signing the attachment.

3. The recipient's signature is optional.

4. The attachment must be dated and signed by the provider requesting/providing the service.

   NOTE: The name and signature of the supervising provider is not required if the performing provider is a physician or psychologist.

APPENDIX 10

PRIOR AUTHORIZATION
AODA SERVICES ATTACHMENT (PA/AA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/AA

PRIOR AUTHORIZATION
AODA SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	IM	A.	1234567890	29

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME AND CREDENTIALS	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
I.M. Performing, A.C.	12345678	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PROVIDER'S NAME	(10) REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
I.M. Referring/Perscribing	87654321

PART A **TYPE OF TREATMENT REQUESTED:**

☒ **PRIMARY INTENSIVE OUTPATIENT TREATMENT**

- ☒ Individual ☒ Group ☒ Family
- Number of minutes per session: 60 Individual 180 Group 60 Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☒ Other (specify) 5X/WK
- Requesting 16 hrs/week, for 4 weeks
- Anticipated beginning treatment date 01/03/91
- Estimated intensive treatment termination date 02/01/91
- Attach a copy of treatment design, which includes the following:
  (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  (b) Description of aftercare/follow-up component

Group 3 HR/day, 5 days/week
Ind. 2-1 HR sessions
Family 2-1 HR sessions

☐ **AFTERCARE/FOLLOWUP SERVICE**

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session: _____ Individual _____ Group _____ Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify) _____
- Requesting _____ hrs/week, for _____ weeks
- Estimated discharge date from this component of care _____

☐ AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session: _____ Individual _____ Group _____ Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify)_____
- Requesting _____ hrs/week, for _____ weeks
- Anticipated beginning treatment date _____
- Estimated affected family member/co-dependency treatment termination date _____
- Attach a copy of treatment design, which includes the following:
  (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  (b) Description of aftercare/follow-up component

PART B

1. Was the recipient in primary AODA treatment in the last 12 months? ☐ Yes ☒ No ☐ Unknown
   If "yes," provide dates, problem(s), outcome and provider of service:

2. Dates of diagnostic evaluation(s) or medical examination(s):

   12/15/90

3. Specify diagnostic procedures employed:

   12/21/90 - INTAKE ALCOHOLISM CHECKLIST & CLINICAL INTERVIEW.

4. Provide current primary and secondary diagnosis (**DSM-III**) codes and descriptions:

303.91 ALCOHOL DEPENDENCE-CONTINUOUS AS MANIFESTED BY MALADAPTIVE PATTERN OF USE FOR 3 YEARS, BLACKOUTS, LOSS OF CONTROL, LEGAL AND FAMILY PROBLEMS ASSOCIATED WITH DRINKING.

296.2 MAJOR DEPRESSIVE DISORDER

5. Describe the recipient's current clinical problems and relevant history; include AODA history:

CLIENT HAS DECIDED TO RECEIVE TREATMENT AND COMMITTED HIMSELF TO ABSTINENCE FROM ALL MIND/MOOD ALTERING CHEMICALS. CLIENT HAS HAD A PATTERNED USE WHICH INCLUDED DRINKING 4-5X/WK CONSUMING 6-18 BEERS PER DRINKING BOUT. CLIENT REPORTS BEING INTOXICATED AT LEAST 1X WEEK. CLIENT BEGAN TRYING TO CONTROL HIS DRINKING ABOUT 2 YEARS AGO AFTER BEING ARRESTED FOR DRUNK DRIVING. SINCE THAT TIME HE HAS RECEIVED ONE OTHER DWI CONVICTION. CLIENT REPORTS GUILT AND SHAME ABOUT HIS BEHAVIOR. HE REPORTS PERIODS OF VIOLENCE WHILE INTOXICATED WHICH OCCURED IN HIS FAMILY. IN ADDITION, CLIENT REPORTS A POSITIVE GENETIC HISTORY FOR ALCOHOLISM, CLAIMING THAT HIS FATHER IS ALCOHOLIC.

6. Describe the recipient's family situation; describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

CLIENT LIVES WITH HIS FAMILY. HIS WIFE REPORTS SHE HAS BEEN CONCERNED ABOUT HIS DRINKING FOR 6 YEARS AND HAS ONLY RECENTLY REPORTED HER CONCERN TO HER SPOUSE. THE CHILDREN IN THE FAMILY CONSISTS OF A 13 Y/O SON AND A 10 Y/O DAUGHTER. THE 13 Y/O WAS VERY QUIET DURING THE FAMILY ASSESSMENT AND DENIED ANY CONCERN ABOUT HIS DAD'S DRINKING. THE DAUGHTER WAS ABLE TO EXPRESS HER WORRY AND ATTEMPTS TO DISCONTINUE HER DAD'S DRINKING. (i.e. HIDING HIS BEER). THE FAMILY AGREED TO ATTEND OUR EDUCATIONAL NIGHT AND ALSO AGREED TO PERIODIC FAMILY SESSIONS. THEY DECIDED AT THIS TIME NOT TO BE INVOLVED WITH MORE INTENSIVE TREATMENT.

7. Provide a detailed description of treatment objectives and goals:

1) CLIENT WILL LEARN BASIC INFORMATION ON ALCOHOLISM.
2) CLIENT WILL BE ABLE TO SHARE HIS DRINKING HISTORY TO GROUP BY THE 2ND WEEK.
3) CLIENT WILL VERBALIZE & IDENTIFY SELF AS ALCOHOLIC.
4) CLIENT WILL CONTINUE ABSTINENCE FROM ALCOHOL.
5) CLIENT WILL DEVELOP A SELF-HELP PROGRAM.
6) CLIENT WILL VERBALIZE IN HIS FAMILY HIS OWN HISTORY WITH ALCOHOL.
7) CLIENT WILL BEGIN TO IDENTIFY & EXPRESS FEELINGS.
8) CLIENT WILL OBTAIN A SPONSOR BY TERMINATION DATE.

8. Describe expected outcome of treatment (include use of self-help groups if appropriate):

CLIENT WILL CONTINUE TO DEVELOP AND MAINTAIN A SOBER LIFESTYLE. CLIENT WILL ALSO PARTICIPATE IN OUR 12 WEEK AFTERCARE PROGRAM. CLIENT WILL RETURN TO GAINFUL EMPLOYMENT.

Recipient Authorization

9. I have read the attached request for prior authorization of AODA services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative (If representative, state relationship to recipient) _____ Relationship _____

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within 3 months of receipt by EDS (initial request) or within 12 months of receipt by EDS (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

10. O.M. Performing — Signature of Performing Provider
Alcohol and Drug Counselor — Discipline of Performing Provider

I.M. SUPERVISING — Name of Supervising Provider
87654321 — Provider Number of Supervising Provider

I. M. Supervising — Signature of Supervising Provider
MM/DD/YY — Date

PA12118MJF/HB3

APPENDIX 11
SUMMARY OF OUTPATIENT AODA AND AODA INTENSIVE OUTPATIENT TREATMENT PRIOR AUTHORIZATION GUIDELINES (FOR USE WITH THE AODA SERVICES ATTACHMENT - PA/AA)

Severity of Illness Indicators

Outpatient AODA and AODA intensive outpatient treatment may be authorized for individuals with a DSM diagnosis of alcohol dependence (303.9), drug dependency (304.0-304.9), or alcohol or other drug abuse (305.0, or 305.2-305.9) when they meet the severity of illness criteria. Among the criteria for adults are:

- the recipient's family environment or living situation is stable enough to permit benefit from outpatient treatment and family members or significant others are supportive of the recipient's recovery goals (or recipient is able to find alternative sources of support).

- the recipient's psychological state is stable enough to permit benefit from treatment or those psychological difficulties that are present are most closely related to the recipient's chemical abuse rather than to another psychological condition.

- the recipient's chemical abuse results in behavioral deterioration, damaged social functioning, or loss of vocational or educational performance.

- the recipient admits an alcohol/drug problem, recognizes the adverse impact the abuse is having on his/her life, and shows sufficient personal responsibility to comply with treatment and is willing to do so.

For adolescents, additional criteria include:

- school environment is stable enough to permit benefit from outpatient treatment.

- family issues may be addressed by program staff or through appropriate referrals.

All recipients must demonstrate:

- a history of recent chemical abuse, the ability to maintain short-term abstinence goals or the potential for relapse which could result in physical or personal harm.

- their physical condition is sufficiently stable to permit benefit from treatment.

Additional Documentation

The provider must document the recipient's AODA treatment history, if any, including outcomes, for the 12 months preceding the request. The treatment plan must contain measurable active treatment goals and objectives and must note any special needs of the recipient. Requests returned for more information do not constitute a denial of service. The provider is responsible for sending adequate, updated information to allow processing of the prior authorization request.

Normative Authorization for Outpatient AODA

Authorization for adults is generally for no more than one to two therapy contacts per week totalling one to three hours. Group therapy is considered the modality of choice. For adolescents not more than two to three contacts per week totalling three to five hours are authorized. Group and family therapy are the modalities of choice. Individual therapy sessions of 60 minutes are considered if documentation is provided to support such a request. Authorization is generally granted for a three-month period. Where therapy is non-intensive, authorization may be for up to a six-month period.

Additional Instructions for Requests for AODA Intensive Outpatient Treatment

The severity of illness criteria for recipients for whom intensive outpatient treatment is requested needs to justify the more intensive treatment. It is assumed that the program design is appropriate for achieving the intended results.

The treatment plan should reflect the following:

- Indication of the family's involvement in the treatment plan.
- The concept of abstinence from alcohol and drugs.
- Involvement in self-help groups for on-going support.
- A plan for aftercare for 6-12 months following intensive outpatient treatment.

Normative Authorization for AODA Intensive Outpatient Treatment

Services are authorized for 4-16 hours a week for 4-16 weeks (e.g., up to 64 hours over an appropriate period of time; 16 hours a week for 4 weeks). A copy of the program design should be submitted along with the request in order that the consultant may determine that the program elements (individual, group, family sessions) are appropriate to the needs of the recipient.

Intensive treatment is generally not authorized if the recipient participated in the same or a similar program in the past 12 months.

If the recipient is receiving other treatment (such as psychotherapy or day treatment for the mentally ill) at the same time as AODA intensive outpatient treatment, this should be indicated. The request should justify the need for such services and indicate how they are coordinated. However, a recipient may not be in AODA intensive outpatient service and intensive mental health day treatment (more than 10 hours per week) concurrently.

Services to Affected Family Members

Services to individuals who have a problem resulting from their relationship to an individual who has been an active alcohol or drug abuser may be reimbursed as AODA services if the individual has an allowable ICD-9-CM diagnosis (as noted in Appendix 3 of this handbook), and their involvement with the alcohol or drug abuser has been very recent. These services may be provided by a certified AODA counselor. Normative authorization is for weekly group, individual, or family therapy.

Services to affected family members who have not recently been involved with an alcohol or other drug abuser are considered psychotherapy services and are subject to the requirements for psychotherapy services.

APPENDIX 12

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT (PA/ETA)

****

The information contained on the Prior Authorization Evaluation and Testing (PA/ETA) Attachment will be used to make a decision about the amount and type of evaluation and testing which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

When the provider performing the evaluation or testing services will also be providing psychotherapy services or when the psychotherapy provider is employed by the same agency as the person providing the evaluation or testing and both will be billed by that agency, the prior authorization psychotherapy attachment must be submitted along with the PA/ETA. One PA/RF may be used indicating the appropriate procedure codes for all requested services. This will simplify future billing by having all services under one prior authorization number which may then be billed on the same claim form.

However, if the evaluation or testing is being performed by a provider whose services are not being billed by the same agency, then separate PA/RFs must be submitted with the appropriate attachments. In these cases, a separate prior authorization number is assigned for the evaluation or testing services and the psychotherapy services, and the services will need to be billed on separate claim forms.

Questions regarding the completion of the PA/RF and/or the PA/ETA may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance Identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

PROVIDER INFORMATION

ELEMENT 6 - PERFORMING PROVIDER NAME
Enter the name of the therapist who will be performing the evaluation or testing.

ELEMENT 7 - PERFORMING PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

ELEMENT 8 - PERFORMING PROVIDER TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - PERFORMING PROVIDER CREDENTIALS
Indicate the credentials of the performing provider.

DOCUMENTATION

A. TYPE OF EVALUATION/TESTING AND RATIONALE

Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting, or to obtain guardianship which would be in the recipient's best interests). **Providers requesting retroactive authorization must document the emergency situation or the court order that justifies such a request and indicate the initial date of service.**

B. TECHNIQUES OR INSTRUMENTS TO BE USED

Indicate the specific tests, instruments or procedures which will be used to conduct the testing or evaluation. These tests, instruments or procedures must be those accepted as standard of practice for the psychiatrist/psychologist (e.g., proposed psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook).

C. OTHER EVALUATIONS

The provider needs to indicate what other evaluations or testing they are aware of that have been done on the recipient in the past two years and why the current request is not duplicative. Where possible attach copies of the evaluations or tests or summaries of their results.

A physician's prescription is not required for these evaluation and testing services.

APPENDIX 13

PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT

MAIL TO:
EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/ETA

PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form).
3. Attach additional information if necessary.
4. Mail to EDS.

RECIPIENT INFORMATION

(1) Last Name	(2) First Name	(3) MI	(4) Medical Assistance Identification #	(5) Age
Recipient	Im	A	1234567390	72

PROVIDER INFORMATION

(6) Performing Provider Name	(7) Performing Provider #	(8) Performing Provider Telephone #	(9) Discipline (circle one): M.D. Ph.D. Other:
I.M. Provider	12222222	(XXX)XXX-XXXX	

A. Indicate the type of evaluation being requested and why this evaluation is needed (If this was a referral, indicate who made the referral). Be specific as to how the recipient will benefit from this evaluation.

An in-depth clinical evalutation is requested which may include appropriate psychological tests to determine recipient's competency and need for guardianship. Four months ago the patient suffered her second CVA (stroke) and presents with both confusion and depression. It is necessary to determine the extent of her cognitive impairment in order to determine whether guardianship should be recommended to the court. The recipient will benefit by having appropriate oversight and protection if her competence to act in her own behalf is found to be impaired (especially in medical decisions, which presently is most problematic since she wants to leave the nursing home but cannot give herself the twice daily insulin shots).

(continued on opposite side)

B. Indicate the techniques or instruments that will be used to conduct the evaluation.

An in-depth clinical interview will be the initial step in this evaluation. If the results are unclear, further psychological testing would be done as is appropriate, possibly to include the Hooper V.O.T., Bender, WAIS, aphasia screening, etc.

C. Indicate other evaluations which you are aware of that have been conducted on this recipient in the past two years. Indicate why requested evaluation does not duplicate earlier evaluations.

Eighteen months ago the patient had an in-depth evalutaion to determine the reasons for lack of compliance to her diabetic diet. It was determined that she mourned the loss of functioning in her left leg and arm because of her stroke two years ago. With the focus being a situational/adaptional one, she underwent three months of brief psychotherapy since, despite her age, testing showed her to be a good treatment candidate. Therapy was moderately successful as she religiously stuck to her diet following therapy.

J. M. Performing, Ph.D. MM/DD/YY

Signature of Performing Provider | Date | Recipient Signature (optional) | Date

APPENDIX 14
SUMMARY OF PRIOR AUTHORIZATION GUIDELINES FOR THE PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT (PA/ETA)

Prior authorization for evaluation and testing is targeted for necessary testing and evaluation subsequent to a differential diagnostic examination. These situations include:

- A significant change in a recipient's clinical status, which requires evaluation in order to ascertain the need for a change in the treatment plan.

- New information appears during treatment (e.g., abuse) which requires more in-depth assessment.

- A change, or potential change, in the recipient's environment (parental separation, possible need for more restrictive placement) for which evaluation is needed to plan intervention.

- Assessment is ordered by the court (e.g., for competency hearing).

Except in extraordinary circumstances, authorization is only granted to psychiatrists and psychologists.

In requesting authorization the provider must:

- Clearly document the need for the evaluation and its potential benefit to the recipient.

- Indicate the specific techniques and instruments which are used in the evaluation. These techniques must conform to usual standards of practice.

- Document other evaluations the provider is aware of which have been performed during the previous two years and demonstrate that the requested evaluation is not duplicative of these.

Requests may be returned to the provider if the information submitted does not allow processing of the prior authorization request. Returned requests are not denials. Providers should attempt to provide all the information requested on the attachment form (PA/ETA).

When all conditions are met, authorization is generally granted for the requested number of hours as long as this time corresponds with the usual and customary time to conduct such evaluations. Providers are reimbursed according to the rates of reimbursement which apply to their provider type and specialty for the evaluation procedure code being billed. Providers are allowed one month to complete evaluations unless they specifically request a longer period of time and document the rationale for this.

Evaluations which are court-ordered following a criminal conviction are not covered WMAP services.

APPENDIX 15
COPAYMENT SCHEDULE FOR PSYCHOTHERAPY AND AODA SERVICES

Psychotherapy/AODA Services

Outpatient psychotherapy/AODA services in excess of 15 hours or $500.00 of accumulated services per recipient, per calendar year, are exempt from copayment. Services to hospital inpatients (place of service 1) are exempt from recipient copayment.

Psychotherapy or AODA Therapy	90844, 90845, W8968	$2.00 per 60 minutes
Evaluation	90801	$1.00 per 60 minutes
Evaluation - Limit Exceeded	W8987	$2.00 per 60 minutes
Group AODA Therapy	W8969	$.50 per 60 minutes/recipient
Biofeedback	90900, 90904, 90908	$.50 per 60 minutes
Group Medical Psychotherapy	90853	$.50 per 60 minutes/recipient
Family Therapy	90846, 90847, W8970	$2.00 per 60 minutes/recipient
Collateral Interview	90887	$2.00 per 60 minutes
Electroconvulsive Therapy	90870, 90871	$0.00
Multiple Family Group Medical Psychotherapy	90849	$2.00 per 60 minutes/recipient
Narconsythesis	90835	$0.00
Chemotherapy Management (medication checks)	90862	$0.00
Medical Hypnotherapy	90880	$0.00

APPENDIX 16
WMAP ALLOWABLE PLACE OF SERVICE (POS) CODES AND TYPE OF SERVICE (TOS) CODES FOR NON-51.42 BOARD-OPERATED CLINICS

ALLOWABLE PLACE OF SERVICE (POS) CODES

POS	Description
1	Inpatient Hospital*
2	Outpatient Hospital
3	Office
4	Home **
7	Nursing Home
8	Skilled Nursing Facility
0	Other (school only except that medication checks are allowed in school and CBRF)

* Services provided to a hospital inpatient by masters level psychotherapists or AODA counselors are not separately reimbursable as mental health/AODA professional services. Group therapy and medication management are not separately reimbursable by any provider as professional mental health or AODA services when provided to a hospital inpatient.

** POS 4 (home) is allowable only for recipients under 21 years of age when the service is prior authorized as a HealthCheck "Other Service."

ALLOWABLE TYPE OF SERVICE (TOS) CODES

TOS	Description
1	Medical Services (physician, psychiatrist) or AODA services
9	Other (psychotherapy services provided by psychologists and master's level providers, and medication checks provided by RNs)

APPENDIX 17

ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit for all services except chemotherapy management and electroconvulsive therapy:

Time (in Minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

The following chart illustrates the rules of rounding and gives the appropriate billing unit for chemotherapy management:

Time (in Minutes)	Unit(s) Billed
1 - 3	0.2
4 - 6	0.4
7 - 9	0.6
10 - 12	0.8
13 - 15	1.0
16 - 18	1.2
19 - 21	1.4
22 - 24	1.6
25 - 27	1.8
28 - 30	2.0
etc.	

APPENDIX 18
WMAP ALLOWABLE PROCEDURE CODES FOR NEUROPSYCHOLOGICAL TESTING

The following procedure codes are the most common procedure codes that are used when billing for neuropsychological testing. These codes may be billed by physicians (using type of service [TOS] code "B") or a doctoral level psychologist (using TOS code "9"). These codes are not subject to the six hour per two-year limit on psychiatric evaluations and diagnostic testing.

Procedure Code	Description
95880	Assessment of higher cerebral function with medical interpretation; aphasia testing
95881	Developmental Testing
95882	Cognitive Testing and Others
95883	Neuropsychological Testing Battery (Halstead-Reiton, Luria, Wais-R) with report, per hour **(effective for dates of service on or after 01/01/93)**

APPENDIX 19
BILLING HINTS FOR MENTAL HEALTH SERVICES BILLED ON THE HCFA 1500 CLAIM FORM

Use this chart and Appendix 20 (sample HCFA 1500 claim form) to better understand EOB messages you may receive. The second column indicates the EOB message, the place in the handbook to find clarifying information, and the claim form element that triggered the message.

EOB	Message, Resource, and Related Claim Form Element
29	Recipient's Last Name does not match number. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 2
614	Recipient's First Name does not match number. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 2
281	Recipient MA number incorrect. MA Card or other eligibility source - Refer to Part A, Section I for more information. Element 1a
229	Claim indicator is missing or incorrect. Refer to Appendix 1 of this handbook Element 1
10	Recipient eligible for Medicare. Bill Medicare first. (Surgical Procedures) Refer to Part A, Appendix 17 Medicare allowed charges - attach Medicare EOMB Medicare denied charges - Element 11 - use M-code and do not attach Medicare EOMB.
273	Resubmit MA covered services Denied by Medicare. Refer to Part A, Appendix 17 Element 11 - use M-code and do not attach Medicare EOMB
278	MA files show recipient has other health insurance. Refer to Part A, Appendix 18 - Bill denied services on separate claim from paid services to maximize benefits. Elements 9 & 29
014	A discrepancy was noted between the other insurance indicator and the amount paid on your claim. Refer to Appendix 1 of this handbook Elements 9 & 29
192	Prior Authorization required for this service. Refer to Section III of this handbook Element 23
424	Billing Provider Name/Number missing, mismatched, or invalid Refer to Section IV-F of this handbook Element 33
425	Performing Provider Name/Number missing, mismatched, or invalid Refer to Section IV-F of this handbook Element 24K

177 Place of Service invalid or not payable
Refer to Appendix 16 of this handbook
Element 24B

388 Procedure code is incorrect (not on EDS file)
Refer to Appendix 3 of this handbook
Element 24D

116 Procedure not a benefit on date of service
Refer to Appendix 3 of this handbook
Elements 24A & 24D

247 Procedure code obsolete for date of service
Refer to Appendix 3 of this handbook
Elements 24A & 24D

172 Recipient is not Eligible for date of service
MA Card or other eligibility source - Refer to Part A, Section I for more information.
Element 24A

171 Claim/Adjustment received after 12 months from date of service
Refer to Part A, Section IX for more information.
Element 24A

100 Claim previously /partially paid on (claim number and R & S date)
Refer to Part A, Appendix 27 for more information.
Adjustment Request Form

91 Referring/Prescribing Physician required
Elements 17 & 17A

218 Prior Authorization required for service(s) exceeding psych/AODA/AODA Day Treatment guidelines
Refer to Section III of this handbook
Element 23

183 Provider not authorized to perform procedure code &/or type of service code
Refer to Appendix 3 & 16 of this handbook
Elements 24C, 24D, 24K, & 33

477 Billing provider indicated on claim not allowable as billing provider
Refer to Section IV-F of this handbook
Element 33

84 Signature and/or Date is missing
Element 31

NOTE: WMAP HCFA 1500 Claim Form Completion Instructions are found in Appendix 1 of this handbook.

APPENDIX 20
BILLING HINTS FOR MENTAL HEALTH SERVICES
SAMPLE CLAIM FORM

229

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

* MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER ( ) (Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 281
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 29, 614	3. PATIENT'S BIRTH DATE MM DD YY SEX M ( ) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other ( )	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ( ) Married ( ) Other ( ) Employed ( ) Full-Time Student ( ) Part-Time Student ( )	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 278, 014	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER 10, 273
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES ( ) NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )	b. AUTO ACCIDENT? PLACE (State) ( ) YES ( ) NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ( ) YES ( ) NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES ( ) NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 91	17a. I.D. NUMBER OF REFERRING PHYSICIAN 91	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES ( ) YES ( ) NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 ___ 3 ___ 2 ___ 4 ___		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 192, 218

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 116		17	7	183	388							425
2 247				116								183
3 172				247								
4 171				183								
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ( ) YES ( ) NO	28. TOTAL CHARGE $	29. AMOUNT PAID $ 278.014	30. BALANCE DUE $

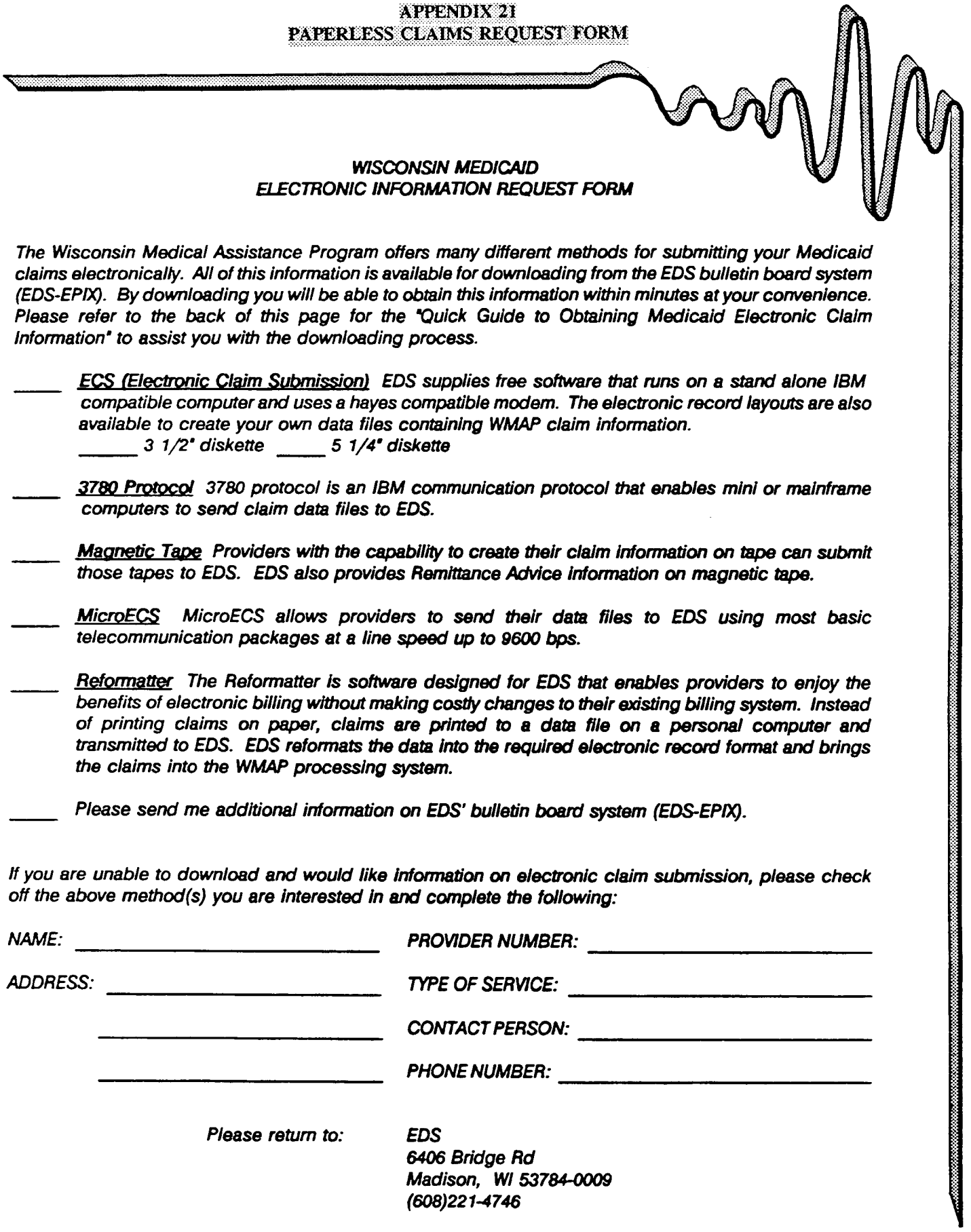
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
84 SIGNED DATE		424, 183, 477 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX 21
PAPERLESS CLAIMS REQUEST FORM



WISCONSIN MEDICAID
ELECTRONIC INFORMATION REQUEST FORM

The Wisconsin Medical Assistance Program offers many different methods for submitting your Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading you will be able to obtain this information within minutes at your convenience. Please refer to the back of this page for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

_____ *ECS (Electronic Claim Submission) EDS supplies free software that runs on a stand alone IBM compatible computer and uses a hayes compatible modem. The electronic record layouts are also available to create your own data files containing WMAP claim information.*
_____ *3 1/2" diskette* _____ *5 1/4" diskette*

_____ *3780 Protocol 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.*

_____ *Magnetic Tape Providers with the capability to create their claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice information on magnetic tape.*

_____ *MicroECS MicroECS allows providers to send their data files to EDS using most basic telecommunication packages at a line speed up to 9600 bps.*

_____ *Reformatter The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the WMAP processing system.*

_____ *Please send me additional information on EDS' bulletin board system (EDS-EPIX).*

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

NAME: _____ *PROVIDER NUMBER:* _____

ADDRESS: _____ *TYPE OF SERVICE:* _____

_____ *CONTACT PERSON:* _____

_____ *PHONE NUMBER:* _____

Please return to:

EDS
6406 Bridge Rd
Madison, WI 53784-0009
(608)221-4746

EDS-EPIX (V 1.1) Quick Guide To Obtaining Medicaid Electronic Claim Information

---

This is a quick guide to retrieving and installing EDS' Electronic Claim Submission software using *EDS-EPIX*.

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS". At the DOS command prompt type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial *EDS-EPIX*. You may need to program your software to dial with the following settings:

Phone Number:	(608) 221-8824	**Stop Bits:**	1
Baud Rate:	9600 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX*. When you go through this initial logon, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu and then view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or 3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu, and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This basically involves telling your communications software package that you wish to "Receive a File", choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software, and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It should be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt type the name of the download file without the ".EXE" extension. For example, for dental software, at the DOS command prompt type:

   DENTAL <Enter>

9. This will extract your software and manual(s).

10. The files ending in .DOC are your manuals. This manual is an ASCII DOS text file. To print this document, use the DOS Print command:

    PRINT *FILENAME*.DOC <Enter>

    The document will be printed on the print device you specify.

APPENDIX 22
WISCONSIN PEER REVIEW ORGANIZATION (WIPRO) REVIEW PROCESS

Admission Review
WIPRO must be notified of the following admissions by the admitting/attending physician or the hospital:

- all AODA admissions to general hospitals or IMDs;
- all elective psychiatric admissions to general hospitals or IMDs; and
- all urgent/emergent admissions to IMDs for recipients under 21 years of age.

At the time the physician or hospital contacts WIPRO, a WIPRO nurse reviewer determines whether the admission is subject to these review procedures and, if so, gathers information over the telephone regarding the patient's medical condition. The WIPRO reviewer uses WMAP psychiatric/AODA criteria to determine whether, on the basis of information provided, the admission appears to be medically necessary. If the reviewer determines that the admission might be "suspect" (i.e., not medically necessary):

1. the reviewer informs the provider that the admission is suspect.
2. WIPRO "flags" the case for retrospective review.

A determination that the medical necessity of the admission might be suspect, for WMAP payment purposes, is made if the admission does not meet the criteria for admission, or if there is not adequate information to determine whether the criteria are met. A decision to recoup WMAP payments for the hospitalization is not made until there has been a review of the recipient's medical record, the recipient has been discharged from the hospital, and a denial determination has been made by a WIPRO physician advisor. Complete medical record documentation is essential for WIPRO in determining the medical necessity of the admission and hospitalization. Physicians must be certain that the patient's record continually and adequately documents the recipient's condition and need for inpatient care.

A control number is issued by WIPRO when notified at the time of admission for all psychiatric and AODA admissions subject to this review. Claims for admissions subject to this review process which do not have a control number are denied.

Retrospective Review
WIPRO also conducts retrospective reviews on targeted psychiatric and AODA admissions. Cases found suspect on admission review are targeted for retrospective review. However, retrospective reviews are not limited to those admissions which must be reported to WIPRO. For instance, urgent/emergent psychiatric admissions which have short lengths of stay or are transfers may also be subject to retrospective review.

If a case is selected for retrospective review, WIPRO requests the recipient's medical record from the hospital. If upon retrospective review, WIPRO determines that the admission or any portion of the inpatient stay was not medically necessary for WMAP purposes, WIPRO informs the hospital, physician, and the WMAP of their final determination.

Special Cases

1. Border status hospitals and court-ordered admissions are subject to WIPRO review process.
2. Dual entitlees (Medicare/Medical Assistance) are subject to WIPRO review process after the recipient's psychiatric benefits under Medicare are exhausted.
3. Cases in which an application for WMAP eligibility is submitted at the time of admission or at any point during an inpatient stay are subject to this review process. If the recipient is determined eligible for WMAP coverage after admission, the hospital must notify WIPRO of the hospitalization prior to submitting the claim so that WIPRO may assign a control number. This type of situation includes separate case eligibility determinations for children admitted to specialty hospitals and recipient retroactive eligibility.

Exempted Cases

1. Recipients in WMAP-contracted managed care programs are exempted from WIPRO review. Managed care programs have their own procedures relative to mental health and AODA services and should be contacted prior to admission for elective services, and within 72 hours after admission for emergency care.

2. Out-of-state hospitals (excluding border status hospitals) are exempted from WIPRO review. Except for emergency care, such stays are subject to prior authorization.

Questions About the Pre-Admission Review (PAR)

All questions about the review of PAR should be directed to WIPRO at 1-800-833-7247 or (608) 274-3832.

Please do not contact EDS with questions regarding this review process